**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**
**EMERGENCY CARE DATA RECORD**
**MANUAL ABSTRACT REPORTING FORM**
***For use with encounters on or after January 1, 2006***



**Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97251 through 97265)**

**A. FACILITY ID NUMBER**

**B. ABSTRACT RECORD NUMBER (Optional)**

**1. DATE OF BIRTH**

Month M M | Day D D | Year (4-digit) C C Y Y

**2. SEX**

F Female
M Male
U Unknown

**3. RACE**

R1 American Indian or Alaska Native
R2 Asian
R3 Black or African American
R4 Native Hawaiian or Other Pacific Islander
R5 White
R9 Other Race
99 Unknown

**4. ETHNICITY**

E1 Hispanic or Latino
E2 Non-Hispanic or Non-Latino
99 Unknown

**5. ZIP CODE**

99999 **=** Unknown

**6. PATIENT'S SOCIAL SECURITY NUMBER**

Report 000000001(Unknown) if not recorded in the patient's medical record

**7. SERVICE DATE**

Month M M | Day D D | Year (4-digit) C C Y Y

**15. EXPECTED SOURCE OF PAYMENT**

09 Self Pay
11 Other Non-federal programs
12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
16 Health Maintenance Organization (HMO) Medicare Risk
AM Automobile Medical
BL Blue Cross/Blue Shield
CH CHAMPUS (TRICARE)
CI Commercial Insurance Company
DS Disability
HM Health Maintenance Organization
MA Medicare Part A
MB Medicare Part B
MC Medicaid (Medi-Cal)
OF Other federal program
TV Title V
VA Veterans Affairs Plan
WC Workers' Compensation Health Claim
00 Other

**A. FACILITY ID NUMBER** | **B. ABSTRACT RECORD NUMBER (Optional)** | **1. DATE OF BIRTH** (MMDDCCYY)

**7. SERVICE DATE** (MMDDCCYY)

**14. DISPOSITION OF PATIENT**

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

**8. PRINCIPAL DIAGNOSIS**
ICD-9-CM CODE

**9. OTHER DIAGNOSIS**
ICD-9-CM CODE

a. b. c. d. e. f. g. h.
i. j. k. l. m. n. o. p.
q. r. s. t. u. v. w. x.

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**
**EMERGENCY CARE DATA RECORD**
**MANUAL ABSTRACT REPORTING FORM**
***For use with encounters on or after January 1, 2006***



**A. FACILITY ID NUMBER**

**B. ABSTRACT RECORD NUMBER (Optional)**

**1. DATE OF BIRTH** (MMDDCCYY)

**7. SERVICE DATE** (MMDDCCYY)

**10 PRINCIPAL E-CODE**
ICD-9-CM CODE

E

**11 OTHER E-CODES**
ICD-9-CM CODE

a. E
b. E
c. E
d. E

**12. PRINCIPAL PROCEDURE**
CPT-4 CODE

**13. OTHER PROCEDURES**
CPT-4 CODE

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
m.
n.
o.
p.
q.
r.
s.
t.

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**
**AMBULATORY SURGERY DATA RECORD**
**MANUAL ABSTRACT REPORTING FORM**
***For use with encounters on or after January 1, 2006***



**Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97251 through 97265)**

**A. FACILITY ID NUMBER**

**B. ABSTRACT RECORD NUMBER (Optional)**

**1. DATE OF BIRTH**

Month Day Year (4-digit)
M M D D C C Y Y

**2. SEX**
F Female
M Male
U Unknown

**3. RACE**
R1 American Indian or Alaska Native
R2 Asian
R3 Black or African American
R4 Native Hawaiian or Other Pacific Islander
R5 White
R9 Other Race
99 Unknown

**4. ETHNICITY**
E1 Hispanic or Latino
E2 Non-Hispanic or Non-Latino
99 Unknown

**5. ZIP CODE**

99999 **=** Unknown

**6. PATIENT'S SOCIAL SECURITY NUMBER**

Report 000000001(Unknown) if not recorded in the patient's medical record

**7. SERVICE DATE**

Month Day Year (4-digit)
M M D D C C Y Y

**15. EXPECTED SOURCE OF PAYMENT**

09 Self Pay
11 Other Non-federal programs
12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
16 Health Maintenance Organization (HMO) Medicare Risk
AM Automobile Medical
BL Blue Cross/Blue Shield
CH CHAMPUS (TRICARE)
CI Commercial Insurance Company
DS Disability
HM Health Maintenance Organization
MA Medicare Part A
MB Medicare Part B
MC Medicaid (Medi-Cal)
OF Other federal program
TV Title V
VA Veterans Affairs Plan
WC Workers' Compensation Health Claim
00 Other

**A. FACILITY ID NUMBER** | **B. ABSTRACT RECORD NUMBER (Optional)** | **1. DATE OF BIRTH** (MMDDCCYY) | **7. SERVICE DATE** (MMDDCCYY)

**14. DISPOSITION OF PATIENT**

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution not defined elsewhere in this code list
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
00 Other

**8. PRINCIPAL DIAGNOSIS**
ICD-9-CM CODE

**9. OTHER DIAGNOSIS**
ICD-9-CM CODE

a. b. c. d. e. f. g. h.
i. j. k. l. m. n. o. p.
q. r. s. t. u. v. w. x.

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**
**AMBULATORY SURGERY DATA RECORD**
**MANUAL ABSTRACT REPORTING FORM**
***For use with encounters on or after January 1, 2006***



**A. FACILITY ID NUMBER**

**B. ABSTRACT RECORD NUMBER (Optional)**

**1. DATE OF BIRTH** (MMDDCCYY)

**7. SERVICE DATE** (MMDDCCYY)

**10 PRINCIPAL E-CODE**
ICD-9-CM CODE

E

**11 OTHER E-CODES**
ICD-9-CM CODE

a. E
b. E
c. E
d. E

**12. PRINCIPAL PROCEDURE**
CPT-4 CODE

**13. OTHER PROCEDURES**
CPT-4 CODE

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
l.
m.
n.
o.
p.
q.
r.
s.
t.

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**

**PATIENT DATA**

**INDIVIDUAL FACILITY TRANSMITTAL FORM**

| **OSHPD Use Only** |
|---|
| PM Date: _____ |
| Agent: _____ |

Facility Name: _____

Facility Identification Number: | | | | | | |

Report Period From: _____ to _____

Total Number of Records: _____

**DISKETTE**

( ) 3½" Diskette

( ) CD-ROM

Filename:

_____

**CERTIFICATION**

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly
(Name of Facility)

authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the definitions of the required data elements in Subsection (g) of Section 128735, or Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this facility.

Dated: _____ By: _____
(Signature)

Facility: _____ Name: _____
(Please Print)

Address: _____ Title: _____

_____ Phone: _____

E-mail: _____

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**

**PATIENT DATA**

**AGENT'S TRANSMITTAL FORM**

**OSHPD Use Only**
PM Date: _____
Agent: _____

Agent's Name: _____

Contact Person: _____ Title: _____

Address: _____

Phone No: (  ) _____ Ext: _____

E-mail _____

**DISKETTE**

( ) 3½" Diskette

( ) CD-ROM

Filename:

_____

| | FACILITY NAME | FAC. ID NO | REPORT PERIOD BEGINNING | REPORT PERIOD ENDING | TOTAL NO OF RECORDS |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |

State of California – Health and Human Services Agency
***Arnold Schwarzenegger, Governor***

Office of Statewide Health Planning and Development
***Healthcare Information Division***
Patient Data Section
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679; Fax (916) 322-9555
www.oshpd.ca.gov/mircal

# Agent Designation Form

In order to designate a third party agent to submit data on your behalf, your facility must complete this form. All information must be provided, including a signature from a facility administrator or primary contact.

*Please print clearly*

## Section 1: Facility Information *(all information is required)*

| | |
|---|---|
| 1. FACILITY ID NUMBER: | 2. FACILITY NAME: |
| 3. DATA TYPE(S): ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery<br>Check one or more Data Type(s). *If none are checked, the Agent will be given access to all Data Types associated with your facility.* | |
| 4. FACILITY BUSINESS ADDRESS (MAILING ADDRESS): | |
| 5. FACILITY CONTACT NAME: | 6. TITLE: |
| 7. PHONE: | 8. E-MAIL ADDRESS: |

## Section 2: Designated Agent Information *(all information is required)*

| | |
|---|---|
| 9. NAME OF DESIGNATED AGENT (COMPANY NAME): | |
| 10. BUSINESS ADDRESS (MAILING ADDRESS): | |
| 11. CONTACT NAME: | |
| 12. PHONE: | 13. E-MAIL ADDRESS: |
| DESIGNATION EFFECTIVE DATE | |
| 14. EFFECTIVE BEGIN DATE: | Designation is effective until OSHPD receives written notification of revocation or new designation. |

By signing this document, I certify that I am an official of my facility and I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated data type(s) and effective date.

| | |
|---|---|
| 15. NAME (PRINT): | 16. TITLE: |
| 17. SIGNATURE: | 18. DATE: |

# PATIENT DATA REPORTING
# EXTENSION REQUEST

To: Office of Statewide Health Planning and Development
Patient Data Section
818 K Street, Room 100
Sacramento, CA 95814
www.oshpd.ca.gov/mircal
(916) 323-7679
**Fax No. (916) 322-9555**
**Fax No. (916) 327-1262**

Date:_____

ATTN: Patient Data Section

1. Facility Name (DBA): _____
2. Address: _____
3. Mailing Address (if different): _____
4. Facility Identification Number: _____
5. Report Period Beginning Date: _____
6. Report Period Ending Date: _____
7. Designated Agent (if applicable): _____
8. Number of Days of Extension Request: _____
9. Justification: (Include the actions taken to produce the data by the required deadline and those factors which prevent submission of the data by the deadline, and those actions to be taken and the time needed to accommodate them):

_____

_____

_____

_____

_____

_____

10. Person Requesting Extension (print): _____
11. Signature: _____
12. Title: _____
13. Phone:_____ E-mail:_____

# User Account Administrator (UAA) Agreement

*Please print clearly*

## Section 1: MIRCal User Account Administrator Information *(all information is required)*

| | |
|---|---|
| 1. FACILITY ID NUMBER: | 2. FACILITY NAME: |
| 3. NAME (FIRST, MIDDLE INITIAL, LAST AND CREDENTIALS): | |
| 4. POSITION (TITLE): | 5. SUPERVISOR NAME: |
| 6. BUSINESS ADDRESS (MAILING ADDRESS): | 7. UNIQUE EMPLOYEE IDENTIFIER :<br>*Note: An identifier that uniquely distinguishes you within your organization.* |
| 8. BUSINESS PHONE: | 9. BUSINESS FAX: |
| 10. E-MAIL ADDRESS: | |
| 11. AUTHENTICATION WORDS: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.* | |
| a. *Your mother's maiden name:* | b. *Your city of birth:* |

I understand that as an appointed MIRCal User Account Administrator on behalf of the facility, I have the responsibility to:

1. Create/add and inactivate user accounts for other MIRCal users within my facility. Creating a user account includes granting access roles for an individual to read, submit and/or correct my facility's confidential data. Removing granted access roles and/or inactivating user accounts revokes this access.
2. Modify the demographic information for my facility's Primary, Secondary and Administrator Contacts. This notifies OSHPD of any changes in name, mailing address, phone number, and e-mail address for each contact. Modifying contact demographic information directly changes the information on the OSHPD database.
3. Change passwords for MIRCal users within my facility. In the event that a user misplaces or forgets their password, they will be directed to contact their User Account Administrator to have it reset. The User Account Administrator should authenticate the user prior to resetting the password and issuing a new password.
4. Unlock MIRCal user accounts. MIRCal will lock user accounts after three (3) unsuccessful log on attempts. When the account is locked, users will be required to contact their User Account Administrator to unlock their account.
5. Reactivate inactive accounts. NOTE: After 270 consecutive days (9 months) of inactivity, MIRCal user accounts may be inactivated.

By signing this document I acknowledge reading, understanding, and agreeing to its contents.

| | |
|---|---|
| 12. USER ACCOUNT ADMINISTRATOR SIGNATURE: | 13. DATE: |

## Section 2: Facility Administrator Approval *(all information is required) To be completed by the Facility Administrator (CEO or equivalent)*

| | |
|---|---|
| 14. FACILITY ADMINISTRATOR NAME: | 15. FACILITY ADMINISTRATOR SIGNATURE: |
| 16. DATE: | 17. PHONE NUMBER: |

The completed form shall be sent to OSHPD for each User Account Administrator needing MIRCal UAA access. Fax (916) 327-1262 or (916) 322-9555

## Section 3: For OSHPD use only

| | | |
|---|---|---|
| Date Received: | Date Authenticated/Enrolled: | By: |
| User Name: | Note: | |

# User Account Administrator (UAA) Agreement Instructions

Make a copy of the completed forms for your records. Send the completed form(s) to:

Office of Statewide Health Planning and Development
Patient Data Section
818 K Street, Room 100
Sacramento, CA 95814
www.oshpd.ca.gov/mircal

Contact Information
Call your OSHPD Analyst or (916) 324-6147
E-mail mircal@oshpd.ca.gov
Fax (916) 327-1262 or (916) 322-9555

SECTION 1: MIRCal User Account Administrator Information *(All fields must be completed) -- To be completed by the prospective MIRCal User Account Administrator.*

1. Facility ID Number: Provide your OSHPD assigned 6 digit facility number.
2. Facility Name: Provide the licensed name of your facility.
3. Name and Credentials: Provide your full name and credentials (if applicable).
4. Position (Title): Provide the position held at your facility.
5. Supervisor Name: Provide the name of your supervisor/manager.
6. Business Address (Mailing Address): Enter the business address where you can receive mail.
7. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization. (I.e. title, badge number, employee number, etc.)
8. Business Phone: Provide a phone number where you can be contacted.
9. Business Fax: Provide a fax number where you can receive faxes.
10. E-mail address: Provide an e-mail address where you can be contacted.
11. Authentication Words: The authentication words provided may be used to identify you in the event that a password reset is required. It is important to remember this information.
    a. Provide your mother's maiden name.
    b. Provide your city of birth.
12. User Account Administrator Signature: If you acknowledge reading, understanding and agreeing to the contents of this document, provide your signature.
13. Date: Provide the date that the facility agreement was completed and signed.

SECTION 2: Facility Administrator Approval (*All fields must be completed) – To be completed by the Facility Administrator (CEO or equivalent). This should be the person who directs the overall management of the facility. OSHPD will cross reference this name against the name supplied by your facility as the MIRCal Facility Administrator contact person.*

14. Facility Administrator Name: Print your name.
15. Facility Administrator Signature: After you have reviewed and approved the completed Facility User Account Administrator Agreement, you must provide your signature indicating approval of person to act as the MIRCal User Account Administrator.
16. Date: Date of signature.
17. Phone Number: Provide a phone number where you can be reached.

SECTION 3: For OSHPD Use Only

# Designated Agent User Agreement

*Please print clearly*

## Section 1: MIRCal Designated Agent User Information *(all information is required)*

| | |
|---|---|
| 1. DESIGNATED AGENT NAME | |
| 2. NAME OF MIRCAL DESIGNATED AGENT USER (FIRST, MIDDLE INITIAL, LAST AND CREDENTIALS): | |
| 3. POSITION (TITLE): | 4. SUPERVISOR NAME: |
| 5. BUSINESS ADDRESS (MAILING ADDRESS): | 6. UNIQUE EMPLOYEE IDENTIFIER:<br>*Note: An identifier that uniquely distinguishes you within your organization.* |
| 7. BUSINESS PHONE: | 8. BUSINESS FAX: |
| 9. E-MAIL ADDRESS: | |
| 10. AUTHENTICATION WORDS: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.* | |
| a. *Your mother's maiden name:* | b. *Your city of birth:* |

I understand that as a Designated Agent User:
1. I can submit data and retrieve the status of the data on behalf of a facility.
2. My MIRCal user account may be inactivated after 270 consecutive days (9 months) of inactivity. Only OSHPD can reactivate my account.

By signing this document I acknowledge reading, understanding, and agreeing to its contents.

| | |
|---|---|
| 11. DATE: | 12. USER SIGNATURE: |

## Section 2: Designated Agent Primary Contact Approval *(all information is required)*

| | |
|---|---|
| 13. PRINT NAME: | 14. DESIGNATED AGENT "*PRIMARY*" CONTACT SIGNATURE: |
| 15. DATE: | 16. PHONE NUMBER: |

The completed form shall be sent to OSHPD for each Designated Agent user needing MIRCal access. Fax (916) 327-1262 or (916) 322-9555

## Section 3: For OSHPD use only

| | | |
|---|---|---|
| Date Received: | Date Authenticated/Enrolled: | By: |
| User Name: | Note: | |

*Please Note: The Facility Administrator or Primary Contact at each facility that you represent must complete and sign the Agent Designation Form (OSHPD 1370.3) approving a Designated Agent to submit data on their behalf.*

# Designated Agent User Agreement Instructions

Make a copy of the completed forms for your records. Send the completed form(s) to:

Office of Statewide Health Planning and Development
Patient Data Section
818 K Street, Room 100
Sacramento, CA 95814
www.oshpd.ca.gov/mircal

Contact Information
Call your OSHPD Analyst or (916) 324-6147
E-mail mircal@oshpd.ca.gov
Fax (916) 327-1262 or (916) 322-9555

SECTION 1: MIRCal Designated Agent User Information *(All fields must be completed) -- To be completed by MIRCal User requesting access to MIRCal.*

1. Name of Designated Agent: Provide the name of your business.
2. Name and Credentials of MIRCal Designated Agent User: Provide the full name of the MIRCal user and credentials (if applicable).
3. Position (Title): Provide the position held in your organization.
4. Supervisor Name: Provide the name of your supervisor/manager.
5. Business Address (Mailing Address): Enter the business address where you can receive mail.
6. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization. (I.e. title, badge number, employee number, etc.)
7. Business Phone: Provide a phone number where you can be contacted.
8. Business Fax: Provide a fax number where you can receive faxes.
9. E-mail address: Provide an e-mail address where you can be contacted.
10. Authentication Words: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.*
    a. Provide your mother's maiden name.
    b. Provide your city of birth.
11. Date: Provide the date that the facility agreement was completed and signed.
12. User Signature: If you understand and agree with the responsibilities and guidelines for maintaining MIRCal security, as detailed in the user agreement, provide your signature.

SECTION 2: Designated Agent Primary Contact Approval *(All fields must be completed) – To be completed by the Designated Primary Contact.*

13. Print Name: Print the name of the Designated Agent Primary Contact.
14. Designated Agent Primary Contact Signature: When the completed information is reviewed and approved, provide your signature indicating approval of person to use MIRCal.
15. Date: Provide the date that this user agreement was approved and signed.
16. Phone Number: Provide a phone number where you can be reached.

SECTION 3: OSHPD Use Only